SURGICAL ETHICS CHALLENGES

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Ethics of medical finance: When is enough too much?

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If the world was perfect, it wouldn't be.

—Lawrence Peter "Yogi" Berra

A well-known vascular surgeon practices at a state university hospital that serves a mixture of insured and indigent patients. He trained before endovascular techniques were available and chose to continue with open techniques exclusively. Further, he has a statewide reputation of accepting difficult cases unsuitable for endovascular therapy. Other vascular surgeons refer complicated Medicaid patients from within the state and also from surrounding states. As one might suspect, he has become very busy. His generosity costs the hospital an average of $25,000 per Medicaid case. Past deficits were made up from discretionary state funds, but since the recession, state budgets are fixed. The hospital CFO established a committee to consider which programs to discontinue. The other programs on the table provide for more essential services. What should the committee recommend to the CFO about this surgeon's practice?

A. Patients he treats likely would not receive lifesaving care without him. Let him continue.
B. Increase charges for the insured to make up the difference.
C. He should not be allowed to operate on patients from out of state.
D. He should be restricted from operating on any Medicaid patients.
E. Form a committee to screen his cases, letting him only operate on the low-risk cases.

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Medical financing is fast approaching a tipping point, with health legislation mandating more care and unsustainable national finances racing onward.[1] The Office of the Actuary, Centers for Medicare and Medicaid Services, predict that when the "[Un]Affordable Health Care Act" fully unleashes in 2 years, the total cost is estimated to reach $3.1 trillion.[2] The federal government will pay almost half. In perspective, the income—not expenditures—of the federal government in 2010 totaled $2.5 trillion. Legislation has retained inefficient medical insurers but limited their influence on medical care delivery. Medical institutions and physicians remain, as they have always been, the bulwark between the government and patient care. The ability to continue in this role is now being sorely tested.

Unlike almost every other financial decision, medical care decisions, except perhaps cosmetic therapies, are not comparative prioritizations. Life and health concerns are preconditions for seeking medical care so that the general consensus is that they are imperative. Unlike other services in which the consumer determines his or her own needs, someone else determines medical necessity for the patient. Cost is often undetermined at the onset. Insurance will cover most of the cost, but often a diminishing share. Patients are assumed to have autonomy when making medical care decisions, another assumption that is sorely tested.

Up until the recent past, decisions about which patients received costly medical therapy primarily involved scarce medical resources, such as organ transplantation, and those who would benefit the most were objective selections. A new era approaches when expensive therapies will be received based on comparative cost-effectiveness. Public medical institutions with large indigent populations have had to choose which extra programs were affordable. Rationing (denying patients what is needed in deliberative clinical judgment) is well established as a pejorative concerning medical care, but unpaid medical care is not unlimited, and public institutions, such as Veterans Health Affairs hospitals, control costs by subtle limitations of accessibility.

Medicine is the one profession that seems to ignore "The Law of Diminishing Returns." The availability of technologically advanced therapies has particularly increased utilization of medical resources in terminally ill

cancer patients without necessarily lengthening their lives or improving their comfort. For example, aggressive chemical and radiation therapy after recurrence and advanced pancreatic cancer metastases typically buys the patient little or no extension of life, but assures additional suffering.[3] Berwick and Hackbarth[4] calculate that 34% of the cost of medical care is from overtreatment, fraud, abuse, and other types of waste. Surgeons have a firewall protecting them from several of the types of waste mentioned: they are a referral specialty, with another physician who will not benefit financially proposing surgical therapy; and most surgeons are not regularly attendings at end-of-life.

We introduced the ethical concept of co-fiduciary responsibility to address shared responsibility of physicians and their medical institutions for the population of patients served by the institution.[5] These include scheduling, credentialing, and financial processes. Surgeons have co-fiduciary obligations and duties with their institutions and other health professionals for the patients served at the institution. Obligations take the form of individual promises such as attending committee meetings. Duties are imposed by the institution for actions necessary for an organization to function. Duties have enforcement penalties if the responsibility is not met. For example, it is the duty of every practicing physician to maintain a medical license. Failure results in loss of privileges.

This case highlights a co-fiduciary responsibility of surgeons and hospitals of growing importance. The surgeon does not have a duty to make the hospital profitable but does have a duty to protect the fiscal viability of the hospital so that it can discharge its co-fiduciary obligation to see to it that all of its patients receive good medical care.

The hospital's appropriate financial interest extends beyond solvency; capital resources are necessary to maintain modern equipment and facilities. As medical costs continue to exceed inflation and GDP increases, medical institutions have seen payers continually implementing plans to control cost. It is a financial tennis match. But now unlike the past, because the entire game has shifted, there will be multiple balls thrown onto the court. As a consequence, the legitimate fiscal interests of a hospital need to be taken into account in setting organizational policy on who should be admitted as a patient.

Option A illustrates the holdover on the abundance paradigm. The three decades of American economic abundance after World War II and the low costs of medical care during this period obscured the importance of co-fiduciary responsibility. The permanent changes wrought by the return of global competition and the fragility of capitalist economies combine to make co-fiduciary financial responsibility unavoidable.

Option B appears attractive because it addresses the reality of economic constraints. However, given the realities of medical indigence required to qualify for Medicaid in most states, increasing charges to the surgeon's moneyed population will not produce revenues sufficient to offset the hospital's losses. There are serious practical limitations to marketplace solutions in health care. Justice being to each according to what they deserve is not necessarily parallel with wealth redistribution.

Option C is a legitimate concern because the state that funds the hospital theoretically has responsibility for its residents but not for the residents of other, neighboring states; that is how the federal system of self-government works in the United States. However, the hospital's responsibility, and especially the surgeon's responsibilities, do not depend on addresses. Fiduciary professionalism has required medical care be given according to need established in deliberative clinical judgment, no other criteria—except scarce medical resources. When resources are short, routine medical care could become classed as scarce to a degree. However, state of residence should not be a criterion in this case. The state government has the prerogative to prohibit out-of-state Medicaid care. Should it do so, then the hospital has adequate policy guidance and could justifiably restrict the surgeon's practice to in-state patients, to whom there is an obligation to provide care using state resources.

Option D is ethically unacceptable inasmuch as the hospital receives funding from the state and, therefore, has a mission to serve the state's sick poor. Option D also fails to recognize that the hospital has some, but reasonably limited, responsibility to provide access to the surgeon's in-state Medicaid patients. The challenge is how to do so in both a professionally and fiscally responsible manner.

Professional responsibility requires recognition that all aneurysms are not equal threats to life. Aneurysms' risks can be classified according to size, location, symptomatology, and comorbidities. The hospital could calculate limits of losses that ould be absorbed and a committee of vascular surgeons, including the "Medicaid surgeon," could prioritize the cases. They could identify other surgeons in other institutions who would be willing to share the burden. Option E becomes the basis for the committee's work: proposing a policy for the hospital and all of its vascular surgeons to make sure that no needed surgical management of in-state Medicaid beneficiaries is foregone.

As Yogi's witticism recognized: there is no perfect world, especially in medicine. Physicians of all nationalities and beliefs have labored over three millennia to make the system of medical care as perfect as possible. How to continue to do so under the constraints of co-fiduciary responsibility becomes a major task of surgical ethics.

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